

Creative Therapeutics 3300 Resource Parkway#5 DeKalb IL 60115

Thank you for choosing our office!! In order to serve you properly, we need the following information. All information will be kept confidential.

Please Print

Patient Name: Last, First, Middle, Initial				Today's Date:	
Home address:		City:		State:	Zip:
Home phone:	Work Phone	Cell phone	Email address:		
Birth date:	Social Security #:		Height :	Weight:	Gender: M F
Circle appropriate: Minor Single Married Divorced Separated Widowed					
Person to contact in case of emergency:		Their Relationship to you:		Their Phone Number:	
Patient's Occupation:	Employment status		Family doctor:		
		Referring physician			
How did you hear about us?					
If we need to reach you can we email or use your cell #?					
May we send you our email newsletter?					

Insurance information:

Insurance company:		Spouse SS# if policy holder			
Patient's (or parent/guardian's) employer:					
Business Address:		City:		State:	Zip:
Spouse (or parent/guardian's) Name:			Spouse's Occupation:		
Spouse (or parent/guardian's) Employer:			Spouse's Work phone:		
Spouse birth date	Policy holder		Policy #		
Relation to insured			Insurance phone number:		
Secondary insurance			Secondary insurance policy number		

I certify that the above information is accurate.

Signature _____ Date _____

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If this is a worker's comp claim please complete the following

Did you report this incident to your employer? yes no	Date of injury	Company Contact phone number
Is your employer aware that you are seeking treatment? yes no	Company contact person	
Place of employment	Human resources representative for company	
Insurance company	Insurance company phone number	
Case number	Please add any information we should know about case	

If this is a motor vehicle accident please fill out the following information

Date of injury	State the accident took place
Insurance company	Policy holder
Policy number	Claim number
Contact person	Contact phone number
Is this your insurance or other parties insurance?	3 rd party name
3 rd party phone	3 rd party address
3 rd party City, state, zip	

Important information regarding your accident: It is unfortunate you have been hurt in a motor vehicle accident. The insurance company for the responsible party appears to be liable for your treatment; however, you are responsible to us for the payment of your treatment should your insurance company deny payment. If your insurance company is not paying your claims as you receive treatment (holding for all treatment to be finished and signed off on) Creative Therapeutics and Acupuncture Health Center require payment at each appointment. Full payment would be appreciated, but you must pay at least a portion of your payment for each treatment. Any charges that are not paid by your insurance company in a timely manner will be billed and due from you.

Signature _____ date _____

FINANCIAL POLICY

Communication with our clients regarding our financial policy assists us in providing the best possible service to you. Please read the following. Your signature is required at the bottom of the page. Thank you.

- **Private Pay** – (clients without insurance) Full payment is required when services are rendered to continue treatment OR payment arrangements need to be agreed upon.
Insurance Company Reimbursement – **Clients are required to contact their insurance company to verify their deductible status and the amount of coverage for physical/occupational therapy available to them.** We will also be contacting your insurance company to verify your coverage. **It is important to remember that what the insurance company tells us is not a GUARANTEE of payment from them.**
- **Deductible and Co-payment** - If you have not previously met your deductible, payment is due in full for your initial evaluation at the time of your first visit. If you have not met your deductible, you will be required to pay the full amount of each visit until you have met it. **We require your co-payment or co- insurance at the time of service.** If you do not know what your co-insurance is, a minimum of 20% is due at the time of service. Any charges that your insurance company does not pay for or denies will be the patient's responsibility.
- **Purchasing products** – **payment for all products are the patient's responsibility.** Payment for products is due at the time of purchase. As a courtesy to you, we will bill your insurance company. If your insurance company does pay for the product, we will credit/refund your account.
- **Worker's Compensation** – All pre-authorized bills will be sent directly to your Worker's Compensation carrier. **If your claim is denied or disputed, you will be responsible for payment** and a payment plan will be arranged.
- **Auto Accident** - You must supply us with the insurance company who is responsible and a contact person. **If they do not pay in a timely manner, or are waiting until the accident is completely settled to make payment - you will be responsible for payment at the time of service.**

AGREEMENT TO PAY

I understand that the agreement with my health insurance, worker's comp carrier or auto accident insurance is an agreement between them and me. I take full responsibility for payment of all charges for professional services rendered. I understand the financial policy detailed above. **I understand that I am responsible for all charges regardless of my existing medical coverage.**

A fee of \$25.00 will be charged for cancellation of my appointment without 12 hours notice or failure to attend a scheduled appointment. NSF checks will be charged a \$25.00 fee.

Consent for Treatment/Release of Insurance Assignment Medical Information

YES _____ NO _____ I authorize any and all therapy service that the provider feels necessary or advisable in conjunction with my referral.

YES _____ NO _____ I assign payment of medical benefits directly to Creative Therapeutics, Ltd.

YES _____ NO _____ I hereby authorize Creative Therapeutics, Ltd. to release to my insurance company, health plan, or insurance group, any medical records or information concerning the treatment to obtain reimbursement on my behalf for the treatment or service provided by Creative Therapeutics, Ltd. I understand that I may revoke the consent to release information to third parties at any time and that the provision of services is not conditioned on my agreement to disclose information to the parties. If I revoke my consent, I will be responsible for paying for all services rendered by Creative Therapeutics, Ltd.

I have read, understand and agree to this financial agreement.

SIGNATURE

DATE

WOMEN'S/MEN'S HEALTH HISTORY FORM

Name: _____ Date: _____

Leisure activities, including exercise routines: _____

Occupation, including activities that comprise your workday: _____

Age: _____ Height: _____ Weight: _____

Are you on a work restriction from your doctor? Yes No Are you latex sensitive? Yes No

Do you smoke? Yes No Do you have a pacemaker? Yes No

FOR WOMEN: Are you currently pregnant or think you might be pregnant? Yes No

ALLERGIES: List any medication(s) you are allergic to: _____

Have you RECENTLY noted any of the following (check all that apply)?

- | | | |
|-----------------------------------------------------------------------|---------------------------------------------------------------|----------------------------------------------|
| <input type="checkbox"/> fatigue | <input type="checkbox"/> numbness or tingling | <input type="checkbox"/> constipation |
| <input type="checkbox"/> fever/chills/sweats | <input type="checkbox"/> muscle weakness | <input type="checkbox"/> diarrhea |
| <input type="checkbox"/> nausea/vomiting | <input type="checkbox"/> dizziness/lightheadedness | <input type="checkbox"/> shortness of breath |
| <input type="checkbox"/> weight loss/gain | <input type="checkbox"/> heartburn/indigestion | <input type="checkbox"/> fainting |
| <input type="checkbox"/> difficulty maintaining balance while walking | <input type="checkbox"/> difficulty swallowing | <input type="checkbox"/> cough |
| <input type="checkbox"/> falls | <input type="checkbox"/> changes in bowel or bladder function | <input type="checkbox"/> headaches |

Have you EVER been diagnosed with any of the following conditions (check all that apply)?

- | | | |
|-----------------------------------------------------------------|-----------------------------------------------------------|------------------------------------------------|
| <input type="checkbox"/> cancer | <input type="checkbox"/> depression | <input type="checkbox"/> thyroid problems |
| <input type="checkbox"/> heart problems | <input type="checkbox"/> lung problems | <input type="checkbox"/> diabetes |
| <input type="checkbox"/> chest pain/angina | <input type="checkbox"/> tuberculosis | <input type="checkbox"/> osteoporosis |
| <input type="checkbox"/> high blood pressure | <input type="checkbox"/> asthma | <input type="checkbox"/> multiple sclerosis |
| <input type="checkbox"/> circulation problems | <input type="checkbox"/> rheumatoid arthritis | <input type="checkbox"/> epilepsy |
| <input type="checkbox"/> blood clots | <input type="checkbox"/> other arthritic condition | <input type="checkbox"/> eye problem/infection |
| <input type="checkbox"/> stroke | <input type="checkbox"/> bladder/urinary tract infection | <input type="checkbox"/> ulcers |
| <input type="checkbox"/> anemia | <input type="checkbox"/> kidney problem/infection | <input type="checkbox"/> liver problems |
| <input type="checkbox"/> bone or joint infection | <input type="checkbox"/> sexually transmitted disease/HIV | <input type="checkbox"/> hepatitis |
| <input type="checkbox"/> chemical dependency (i.e., alcoholism) | <input type="checkbox"/> pelvic inflammatory disease | <input type="checkbox"/> pneumonia |

Has anyone in your immediate family (parents, brothers, sisters) EVER been diagnosed with any of the following conditions (check all that apply)?

- | | | |
|----------------------------------------------|-------------------------------------|-------------------------------------------|
| <input type="checkbox"/> cancer | <input type="checkbox"/> diabetes | <input type="checkbox"/> tuberculosis |
| <input type="checkbox"/> heart problems | <input type="checkbox"/> stroke | <input type="checkbox"/> thyroid problems |
| <input type="checkbox"/> high blood pressure | <input type="checkbox"/> depression | <input type="checkbox"/> blood clots |

For women only:

Number of pregnancies: _____ Number of vaginal births: _____ Number of cesarean births _____

Date of last period: _____

Are your periods regular? YES NO

During the past month have you been feeling down, depressed or hopeless? YES NO

During the past month have you been bothered by having little interest or pleasure in doing things? YES NO

Is this something with which you would like help? YES YES, BUT NOT TODAY NO

Do you ever feel unsafe at home or has anyone hit you or tried to injure you in any way? YES NO

Please list any medications, supplements or hormones you are currently taking (INCLUDING pills, injections, and/or skin patches):

- 1. _____ 2. _____ 3. _____
- 4. _____ 5. _____ 6. _____

Have you ever taken steroid medications for any medical conditions? YES NO

Have you ever taken blood thinning or anticoagulant medications for any medical conditions? YES NO

Please list any surgeries or other conditions for which you have been hospitalized, including dates:

- 1. _____ 2. _____ 3. _____

What date (roughly) did your present symptoms start? _____

What do you think caused your symptoms? _____

My symptoms are currently: Getting Better Getting Worse Staying about the same

Treatment received so far for this problem (chiropractic, injections, etc) _____

Please list special tests performed for this problem (x-ray, MRI, labs, etc) _____

Have you ever had this problem before: Yes No When _____ Treatment rec'd _____

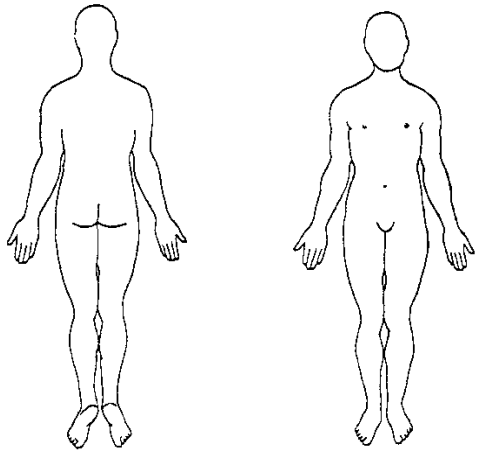
How long did it take for you to feel better? _____

If you have pain, please fill out below:

Body Chart:

Please mark the areas where you feel symptoms on the chart to the right with the following symbols to describe your symptoms:

- ↓ Shooting/sharp pain
- Dull/aching pain
- ||| Numbness
- = Tingling



My symptoms currently: Come and go Are Constant Are constant, but change with activity

Aggravating Factors: Identify up to 3 important positions or activities that make your symptoms worse:

- 1. _____
- 2. _____
- 3. _____

Easing Factors: Identify up to 3 important positions or activities that make your symptoms better:

- 1. _____
- 2. _____
- 3. _____

How are you currently able to sleep at night due to your symptoms?

- No problem sleeping Difficulty falling asleep Awakened by pain Sleep only with medication

When are your symptoms worst? Morning Afternoon Evening Night After exercise

When are your symptoms the best? Morning Afternoon Evening Night After exercise

Using the 0 to 10 the scale, with 0 being “no pain” and 10 being the “worst pain imaginable” please describe:

Your current level of pain while completing this survey: _____

The best your pain has been during the past 24 hours: _____

The worst your pain has been during the past 24 hours: _____

If you have incontinence, bladder urgency or frequency, please fill out the following:

Using the 0-10 scale with 0 being “no affect” and 10 being “severely affected” please describe how your bladder affects your life: _____

Please check which applies to you:

Daytime Toileting:

- Every 4 hours
- Every 2-3 hours
- Every hour
- Every 30-59 minutes
- Other _____

Amount of Urine Leaked:

- A few drops
- A small gush or spurt
- A large leak
- Varies

Nighttime Toileting:

- Rarely/Never
- Once a night
- 2-3 times a night
- More than 3 times a night
- Other _____

Protection Used (if used):

- Adult continence products _____ per day
- Sanitary pads _____ per day
- Pantiliner _____ per day
- Other _____

Leaking Urine Nighttime:

- Rarely/never
- 1-2 nights per week
- 2-3 nights per week
- More than 3 nights per week
- Other _____

Activities Related to Leaking:

- Coughing/Sneezing
- Laughing
- Walking
- Position Change
- Sit to Stand
- Bending/Lifting
- Running/Jumping
- Aerobics
- Water Running/Shower
- Feeling Cold
- During Intercourse
- Before/during Menstration
- Key in the door
- When constipated
- Other _____

Leaking Urine Daytime:

- Once every 2 weeks
- Once per week
- 2-3 days per week
- 4 or more days a week
- Once a day
- Multiple times a day
- Constantly all day
- Other _____
- Morning primarily
- Afternoon primarily
- No pattern

Perception of Need to Urinate:

- No perception of bladder fullness
- Leaks immediately after awareness
- Leaks 1-2 minutes after awareness
- Toileting awareness without problem
- Other _____

Observations During Urination:

- Difficulty initiating the stream
- Weak/slow urine stream
- Dribbling after the stream ends
- Feeling like you do not empty all the way
- Pain during urination
- Burning during urination
- Blood in the urine
- Abnormal color
- Abnormal odor
- Other _____

Bowel Patterns:

- Frequent diarrhea
- Frequent constipation
- Daily BM
- BM every 2-3 days
- BM every 4-5 days
- Use laxatives
- Other _____

Fluid Intake:

- Caffeine consumption (# cups per day)
- Alcohol intake (# drinks per day)
- Total fluid consumption (# glasses per day)

Exercise History:

- Daily
- 5-6 times per week
- 3-4 times per week
- 1-2 times per week
- None

Describe type and duration _____

Patient Signature _____ Date _____

OR Parent/Guardian signature